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Accredited Facilities Bylaw

(Under Section 183 of The Regulated Health Professions Act)

The College of Physicians and Surgeons of Manitoba

(Enacted by the Councillors of the College of Physicians and Surgeons of Manitoba on November 22, 2018 repealing and replacing Bylaw #3 and 3D under The Medical Act)

Effective Date January 1, 2019

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Preamble

Prior to making this Bylaw, the Minister must be provided with a copy of the proposed Bylaw for review and Council must review and consider any comments made, pursuant to s. 183 of the RHPA.

PART A – DIAGNOSTIC FACILITIES

Application of this Part

Part A of this Bylaw applies as follows:

1. Pursuant to The Regulated Health Professions Act(RHPA), ss 183(1)[1], to all diagnostic facilities in Manitoba in which services are performed by members of the College, other than those under the jurisdiction of the provincial or municipal governments and those designated as hospitals under *The Health Services Insurance Act, and a facility or class of facilities exempted by Regulation from the application of s.183(1) of the RHPA*.

2. Pursuant to *s.183(15)[2] of the RHPA* and pursuant to the Service Purchase Agreement made between the College of Physicians and Surgeons of Manitoba and the Government of Manitoba governing diagnostic facilities, to those diagnostic facilities falling within the jurisdiction of the Government of Manitoba as specified in the Service Purchase Agreement.

Article 1 - Definitions

1.1. In Part A of Bylaw:

1.1.1. "**accreditation**" means a review process conducted by the College to determine whether the facility being reviewed meets the standards specified by the College.

[1] 183(1) This section applies to any facility in which a member performs or causes to be performed diagnostic or treatment services, such as a non-hospital medical or surgical facility or a nuclear medicine facility, other than
(a) a facility that is designated as a hospital under *The Health Services Insurance Act*;
(b) a hospital or health care facility operated by the government, the government of Canada or a municipal government; and
(c) a facility or class of facility exempted by regulation from the application of this section.

[2] 183(15) The council may enter into agreements with the government, the government of Canada or a municipal government to make this section applicable to any facility or any part of a facility that falls within that government's jurisdiction.

1.1.2. **“anatomic pathology laboratory”** means a place where human surgical tissue biopsies and specimens, cytological specimens and autopsies are examined for diagnostic purposes.

1.1.3. **"certificate of accreditation"** means a certificate issued under this Bylaw.

1.1.4. **“clinical pathology laboratory”** means a place where diagnostic testing is performed on human samples including the disciplines of chemistry, hematology, transfusion medicine, cytology, immunology, microbiology, virology, histology or pathology.

1.1.5. **“Committee”** means the Program Review Committee of the College.

1.1.6. **“diagnostic imaging facility”** means a place where imaging techniques are used for diagnostic purposes including radiography, ultrasound, computed tomography, magnetic resonance imaging, fluoroscopy, mammography or nuclear medicine.

1.1.7. **“facility”** means a place or a vehicle, whether privately owned or affiliated with or administered by a hospital or other health facility, which is principally equipped to perform a procedure normally performed in an anatomic pathology laboratory, a clinical pathology laboratory, a diagnostic imaging facility or a patient service centre. A clinical pathology laboratory facility may be comprised of a primary location, which is its laboratory, and one or more patient service centres.

1.1.8. **“facility director”** means a physician appointed as director of a facility in accordance with this Bylaw and is synonymous with the term “medical director” used in section 183(3) of the RHPA.

1.1.9. **“patient service centre”** means a location for the collection and/or testing of specimens of blood and of body fluids for the purpose of testing in an accredited laboratory.

1.1.10. **“physician office laboratory”** means a physician’s office where specimens are collected and tested by the physician or a laboratory technician/assistant qualified by training from an accredited medical laboratory technician/assistant training program and is certified or eligible for certification with the Canadian Society of Medical Laboratory Science for the diagnosis of the physician’s own patients.

1.1.11. **“standards”** means the standards approved by Council for facilities.

1.1.12. **“vehicle”** means a device in, upon or by which diagnostic equipment is transported upon a roadway and which is:

1.1.12.a. used primarily for the purpose of offering diagnostic services; and
1.1.12.b. has the approval of the Government of Manitoba to offer diagnostic services in Manitoba but does not include an emergency vehicle as defined in *The Highway Traffic Act*.

1.1. In this Bylaw, words and phrases defined in *The RHPA* have the same meaning as in the *RHPA*.

Article 2 - Facility Accreditation

2.1. A facility is required to obtain accreditation before it offers any services to the public.

2.2. Accreditation of a facility must be:
2.2.1. except in the case of a vehicle, for a specific address or addresses.
2.2.2. for the fixed period of time determined by the Committee, to a maximum of 5 years.
2.2.3. for the procedures specified with the certificate of accreditation.

2.3. In the case of a vehicle, the facility must provide a current mailing address for the owner and the operator of the service.

2.4. Prerequisites to full accreditation of a facility pursuant to this By-law are:
2.4.1. compliance with the relevant standards; and
2.4.2. appointment of a facility director acceptable to the Committee.

2.5. The Committee must establish and make available on request:
2.5.1. standards for each type of facility.
2.5.2. the accreditation process for each type of facility.
2.5.3. the Committee's policies governing the accreditation process for each type of facility.

2.6. Applications for accreditation of a facility must be made to the Committee by the facility director, on the forms prescribed by the Committee, and must contain the information required by the Committee.

2.7. Facility director and personnel who are subject to the accreditation process must cooperate fully, which includes but is not limited to:
2.7.1. permitting inspectors to enter the facility and inspect the premises and all diagnostic equipment located therein.
2.7.2. permitting inspectors to inspect all records pertaining to the provision of services and providing copies of the same if so requested.
2.7.3. providing requested samples or copies of any material, specimen, radiological image or product originating from the diagnostic service.

2.7.4. answering questions posed by the inspectors as to the procedures or standards of performance relating to examinations/procedures performed.

2.8. Where an inspection is conducted as part of the accreditation process, and deficiencies are observed, the Committee must issue a report of the inspection and must provide a copy of the report to the applicant.

Full Accreditation

2.9. Where a facility fully complies with the relevant standards, the Committee will grant full accreditation and will specify with the certificate of accreditation the procedures for which the facility is accredited.

Accreditation Not Granted

2.10. Where accreditation is not granted, the Committee must provide written notice of its decision and the reasons therefor and information on the right of appeal to the Executive Committee.

Conditional Accreditation

2.11. Where a facility does not fully comply with the relevant standards, but the Committee is of the opinion that it is in the public interest to permit the facility to operate while it corrects specified deficiencies, the Committee may grant conditional accreditation.

2.12. Where conditional accreditation is granted, the Committee must:

2.12.1. provide written notice of its decision and the reasons therefor and the information on the right of appeal to the Executive Committee.

2.12.2. state in its decision a fixed deadline for the facility to comply with all relevant standards and for the facility director to provide written confirmation of compliance to the Committee.

2.12.3. state in its decision whether a follow-up inspection must occur before full accreditation may be granted.

2.13. The Committee may extend the deadline for compliance with standards fixed pursuant to Article 2.10 if, in its sole discretion, the Committee deems it appropriate to do so.

2.14. Where a facility with conditional accreditation has not complied with the conditions of accreditation within the time frame fixed by the Committee, the Committee may:

2.14.1. direct an inspection.

2.14.2. withdraw the conditional accreditation and if the facility is publicly owned, report the matter to government with the request that the government require the facility to cease operation.

2.15. If the Committee is of the opinion that it is unsafe for the facility to provide services, it must direct the Registrar to notify the public of the deficiencies and to require that physicians not use the diagnostic facility.

Accreditation Status Review

2.16. Accreditation status may be reviewed at the discretion of the Committee.

Temporary Accreditation

2.17. Temporary accreditation may be granted for the continued operation of a facility, if the facility is already accredited, in circumstances which the Committee deems appropriate, pending the completion of the re-accreditation process.

Article 3 – Maintenance of Accreditation

3.1. In order to maintain accreditation, a facility must:
- 3.1.1. comply with the relevant standards.
- 3.1.2. perform only the procedures permitted pursuant to the facility's certificate of accreditation.
- 3.1.3. at all reasonable times, be open for investigation and inspection by the Committee, with or without notice of the Committee's intention to inspect.
- 3.1.4. cooperate with and participate in the inspection process approved by the Committee for its type of facility.

3.2. During the currency of a full or conditional accreditation the Committee may direct an inspection for the purpose of monitoring compliance, if the Committee is of the opinion that:
- 3.2.1. a facility may not meet the relevant standards or practice.
- 3.2.2. an inspection would be in the public's best interest.

Article 4 – Variance of Accreditation

4.1. A facility may apply at any time to vary its accreditation.

Article 5 – Renewal of Accreditation

5.1. In order to renew accreditation, a facility must re-apply for accreditation at least six months prior to the expiration date of the existing accreditation.

Article 6 – Cancellation of Accreditation

6.1. Where a facility is no longer providing patient services, the Committee may cancel the facility's accreditation.

6.2. Council may cancel accreditation in accordance with The Regulated Health Professions Act.

Article 7 – Facility Director

7.1. A facility must have a facility director.

7.2. A facility director must be a physician whose credentials are acceptable to the Committee.

7.3. The Committee must establish and make available on request the qualifications for facility directors in each type of facility.

7.4. The facility director is responsible for granting privileges to any physician who wishes to work for the facility and notifying the Committee of the physicians who are granted privileges. Before granting privileges to any physician a facility director must:

7.4.1. define in writing the qualifications and competencies required in order to obtain privileges in each field of practice.

7.4.2. obtain written confirmation that the applicant is registered and licensed to practice medicine in Manitoba.

7.4.3. obtain full particulars of the applicant's education, training, competencies and experience.

7.4.4. take reasonable steps to ensure that the applicant has the education, training competencies and experience required, and that the applicant is otherwise a suitable candidate for privileges.

7.5. Within one year of first granting privileges to a physician, the facility director must review that physician's privileges. Thereafter, privileges must be reviewed by the facility director at least every two years.

7.6. Before granting renewal of privileges or extending the existing privileges of any physician, the facility director must take reasonable steps to ensure that the physician has the education, training, competencies and experience required for each field of practice for which he or she is seeking privileges within the facility.

7.7. The facility director must have effective control of and be responsible for the safe operation and administration of the facility, the supervision of all professional, technical

and administrative activities of the facility, and for compliance with this Bylaw and with the relevant standards established by the Committee.

7.8. Without limiting the generality of the foregoing, the facility director must:

7.8.1. have access to all records and documents relating to the operation of the facility and the procedures performed therein.
7.8.2. communicate with any facility under his/her direction a minimum of once per year.
7.8.3. ensure that quality management system requirements and improvement programs are in place.
7.8.4. ensure that the facility has current up to date policies and manuals as required by the standards for that facility.
7.8.5. ensure that complete and accurate patient records and documentation relating to the operation of the facility and procedures performed are kept.
7.8.6. ensure that no procedure is carried out in the facility unless it is permitted by the certificate of accreditation.
7.8.7. ensure that technologists have the qualifications as provided by training from an accredited:
7.8.7.a. medical laboratory training program and are certified or eligible for certification with the Canadian Society of Medical Laboratory Science.
7.8.7.b. medical radiology technology training program and are certified or eligible for certification with the Canadian Association of Medical Radiology Technologists.
7.8.8. ensure that medical laboratory technologists who are required to perform x-ray examinations and medical radiology technologists who are required to perform laboratory testing have graduated from a cross-training program.
7.8.9. ensure that laboratory technicians/assistants have the qualifications as provided by training from an accredited medical laboratory technician/assistant training program and are certified or eligible for certification with the Canadian Society of Medical Laboratory Science.
7.8.10. ensure that persons who provide services to the facility maintain competence to perform the procedures for which the facility is accredited.
7.8.11. ensure that work referred out of the facility is performed by persons with appropriate qualifications and competence to perform the work.
7.8.12. promptly notify the College of any change in the ownership or directorship of the facility.
7.8.13. promptly notify the College if the facility is no longer providing patient services.
7.8.14. where applicable, be available for consultation with referring physicians.
7.8.15. promptly notify the Committee if there is a major change in the following:
7.8.15.a. equipment.
7.8.15.b. the accredited list of diagnostic imaging examinations, laboratory or transfusion medicine tests, or blood and blood products dispensed.
7.8.16. Ensure that the duties and responsibilities of all personnel are written and understood;

7.8.17. Ensure adequate quality assurance and improvement programs are in place

7.9. The facility director must submit to the College such information as required by the Committee.

Article 8 - Appeal

8.1. The facility or a physician who has been adversely affected by a decision of the Committee may appeal the decision of the Committee. The appeal must be made by filing a written notice of appeal with the Council within 30 days after the person receives notice of the decision. The notice of appeal must specify the reasons for the appeal.

Article 9 - Fees

9.1. A privately-owned facility must pay all expenses, charges and fees incurred by the College in relation to the accreditation or inspection of that facility.

Article 10 – Physician Office Laboratory

10.1. Physicians must not operate a physician office laboratory without first obtaining the written approval of the College.

10.2. The Committee may direct the inspection of any facility where physician office laboratory procedures are performed.

Article 11 - Standing

11.1 Revoked

Article 12 - Transition

12.1. A facility that holds accreditation at the time this Bylaw comes into force continues to hold that accreditation status under this Bylaw in accordance with the terms of that accreditation.

12.2. A facility which has not undergone the accreditation process will be notified in writing by the College that it is exempt from the requirement of accreditation set forth in this Bylaw

until the inspection process for that facility is complete and a report is issued, but the facility must cooperate with the College for the timely completion of its accreditation process in accordance with this Bylaw.

12.3. A physician who holds a facility directorship at the time this Bylaw comes into force continues to hold that status under this Bylaw.

PART B – NON-HOSPITAL SURGICAL FACILITIES

Article 13 - Application of this Part

13.1 Subject to section 183 of the RHPA and Article 13.3 of this Bylaw, Part B of this Bylaw applies to all non-hospital medical/surgical facilities that carry out diagnostic and treatment procedures.

13.2 Subject to Article 13.3, Part B of this Bylaw applies to the following procedures:

13.2.1 Any procedure that is carried out with the concurrent use of:

13.2.1.1 procedural sedation, or

13.2.1.2 local, regional or general anesthesia,

provided that the standard of care requires monitoring of vital signs as a result of the administration of the drug to induce sedation or anesthesia;

13.2.2 Any procedure that the Committee directs must be performed in an approved non-hospital surgical/medical facility in order to meet the minimum acceptable standard of care for that procedure.

13.3 This Part of the Bylaw does not apply to any facility which is wholly owned and operated by a Regional Health Authority.

Article 14 - Definitions

14.1. In Part B of this Bylaw:

“accreditation” means the approval granted by the College to a non-hospital medical/ surgical facility to carry out certain diagnostic and/or treatment procedures.

"certificate of accreditation" means a certificate issued to a non-hospital medical/surgical facility by the committee of the College certifying that it has received accreditation.

"committee" means the committee of the College responsible for the administration of this Part only of the Bylaw.

“direct or indirect financial interest” means any interest owned by a member, by individuals connected by blood relationship, marriage or adoption to a member, by any corporation, proprietorship, partnership, society, business, association, joint venture, group or syndicate in which a member or any individual connected by blood relationship, marriage or adoption to a member have any interest.

"director" means a physician who is appointed the director of a non-hospital medical/surgical facility.

"facility" means a non-hospital medical/surgical facility for the purposes of Part B of this Bylaw.

“general anaesthesia” means a controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, including inability to maintain an airway independently, or to respond purposefully to physical stimulation or verbal command, produced by pharmacologic or non-pharmacologic methods, alone or in combination.

“hospital” means a hospital under *The Hospitals Act* with an operational Emergency Department.

"privileges" means the authority to admit and treat patients at a facility.

“procedural sedation” means an altered or depressed state of awareness or perception of pain brought about by pharmacologic agents and which is accompanied by varying degrees of depression of respiration and protective reflexes in which verbal contact with the patient can be maintained, and

i. includes, but is not limited to, the use of any IV agent for this purpose; and
ii. requires the monitoring of vital signs,

but does not include the use of oral pre-medication alone or in combination with local anaesthesia. No distinction is made between light and deep procedural sedation for credentialing or monitoring purposes.

"procedure" means the diagnostic and treatment procedures, both medical and surgical, as approved by the committee to be carried out in a facility.

Article 15 - Facility Accreditation

15.1 A facility seeking accreditation must:

15.1.1 apply on the form prescribed by the committee, specifying the procedures for which accreditation is sought;

15.1.2 provide full and complete details of the facility's ownership, the facility's administration and a list of all members who wish to have privileges to carry out procedures at the facility, including but not limited to: the names of the director(s) and owner(s) of the facility, including any members who have direct or indirect financial interest in the facility, and a medical corporation has a direct or indirect financial interest, the names of the medical corporation's officers and directors;

15.1.3 provide the name of the facility director, a written outline of his or her duties and responsibilities, an outline of the facility's administration, and an organization chart; and

15.1.4 submit the application form, signed by the director, and supporting documents to the committee with the prescribed fee for the application and inspection processes.

15.2 The accreditation process will include:

15.2.1 completion of a pre-visit questionnaire;

15.2.2 an on-site inspection by one or more members, with expertise in the appropriate area of medical practice, designated by the committee;

15.2.3 review of the facility's compliance with the College's standards; and

15.2.4 providing the Minister with a copy of each application and report as required by section 183(17) of the RHPA.

15.3 In circumstances which the committee deems appropriate, provisional approval may be granted for the operation of a facility pending the completion of the accreditation process.

15.4 On completion of the accreditation process, the committee may:

15.4.1 grant full accreditation and issue a certificate of accreditation to a facility if the committee is satisfied that the facility has met all of the requirements of Part B of this Bylaw and there are no identified deficiencies.

15.4.2 grant conditional accreditation to a facility with identified deficiencies and issue a conditional certificate of accreditation specifying the date it will expire if the identified deficiencies are not corrected.

15.4.3 deny accreditation pending correction of identified deficiencies in accordance with s. 183(7) of the RHPA.

15.5 Where conditional accreditation is granted, the director must provide a written response to each deficiency within the time specified by the committee, and a follow-up inspection may occur, if the committee so directs. Full accreditation will only be granted when identified deficiencies have been corrected to the satisfaction of the committee.

15.6 A certificate of accreditation will be issued by the committee for a period not to exceed five years.

15.7 Each certificate of accreditation must append a schedule of procedures approved for the facility.

15.8 Where a facility is no longer being used for the procedures set out in Article 15.7, the committee may revoke the facility's certificate of accreditation.

15.9 If the committee is of the opinion that a facility is not meeting the requirements of Part B of this Bylaw or is unsafe, the committee must review the facility's accreditation and may take such steps with respect to the facility's accreditation as the committee deems appropriate in the circumstances. Where the committee is of the opinion that a facility does not meet the required standards, the committee must report the matter pursuant to s. 183(9) of *The Regulated Health Professions Act.*

15.10 In order to renew a certificate of accreditation, the facility must apply for renewal of accreditation at least six months prior to the date the certificate of accreditation is to expire. The re-accreditation process will follow the same procedure as required for accreditation. Where an application to renew is pending, the facility's accreditation continues until a decision is made on the renewal application.

15.11 The facility must inform the committee of any changes in the information provided in its application for accreditation within 15 days of the date of the change.

Article 16 - Hospital Agreement

16.1. Every facility must have a written agreement with a hospital or a Regional Health Authority pursuant to which the hospital or the Regional Health Authority agrees to provide emergency treatment if a patient has to be transferred from the facility.

Article 17 - Approved Procedures

17.1. Each certificate of accreditation must include a schedule listing the procedures which have been approved for the facility, and the names of the members who have been given privileges to perform the procedures at the facility.

17.2. The schedule of procedures may be amended from time to time upon the application of the facility and the approval of the committee.

17.3. Only those procedures which are approved by the committee and set out in the schedule to the facility's certificate of accreditation may be performed in the facility

Article 18 - Privileges

18.1 A facility must not grant privileges to a member unless:
- 18.1.1 the member qualifies for privileges in accordance with this Part of the Bylaw, or
- 18.1.2 the member's application for privileges is expressly approved by the College.

18.2 An applicant seeking privileges at a facility must:
- 18.2.1 apply in writing to the director,
- 18.2.2 provide to the director:
  - 18.2.2.a a description of any privileges currently held in a hospital or a Regional Health Authority in the city or the municipality where the facility is located; and
  - 18.2.2.b a letter from the hospital or Regional Health Authority confirming the privileges held and the good standing of the applicant.

18.3 Provided that:
- 18.3.1 the applicant complies with the requirements of Article 18.2,
- 18.3.2 the privileges sought by the applicant are no greater than those the applicant holds at a hospital or the Regional Health Authority in the municipality or the city where the facility is located,
- 18.3.3 the director is satisfied that the applicant is a suitable candidate for the privileges requested, and
- 18.3.4 the director may grant privileges to the applicant.

18.4 Within 15 days of granting privileges pursuant to Article 18.2, the director must provide, to the College, particulars of the privileges granted in the facility and, upon request by the College, a copy of the correspondence from the hospital or the Regional Health Authority referred to in Article 18.2(b)(ii).

18.5 A member seeking privileges who does not hold the same or similar privileges in a hospital or a Regional Health Authority in the municipality or the city where the facility is located must provide to the director:
- 18.5.1 details of the same or similar privileges, if any, currently held in other facilities;
- 18.5.2 numbers of procedures performed during the past year similar to those for which he/she is seeking privileges and the name(s) of the facilities in which they were performed;
- 18.5.3 any other relevant past experience; and
- 18.5.4 the names of two referees who can be consulted as to the skill and judgment of the member to perform such procedures.

18.6 For any application made pursuant to Article 18.5, the director must forward to the College:
- 18.6.1 a copy of the application,
- 18.6.2 the director's assessment of the suitability of the applicant for the privileges requested, and
- 18.6.3 a letter from the Regional Health Authority or an appropriate hospital located in the municipality or city in which the facility is located confirming that patients treated by the applicant at the facility shall be treated and admitted to a hospital, as necessary, under the care of members who have appropriate credentials and privileges.

18.7 In considering an application made pursuant to Article 18.5, the committee may request such further or other information as it deems necessary to assess the application.
- 18.7.1 The committee may grant privileges to a member who does not have the same or similar privileges at a hospital or a Regional Health Authority in the municipality or the city in which the facility is located only on the following conditions:
  - 18.7.1.a the member shall be subject to a periodic review conducted by the director and/or any other person(s) deemed appropriate by the committee, to ensure maintenance of competence of the procedures he or she performs; and
  - 18.7.1.b where applicable, a process for reviewing pathology reports shall be established and followed by the facility.

18.8 Any member who performs procedures without obtaining privileges in the facility and any director who permits a member to perform procedures without obtaining privileges in the facility may be found guilty of professional misconduct.

Article 19 - Patient Care

19.1 In a facility:
- 19.1.1 All patients proposed to undergo anaesthesia in a facility must be assigned an American Society of Anaesthesia risk score.
- 19.1.2 Only patients with ASA I, II and III Risk scores may have a procedure performed.
- 19.1.3 General anaesthesia must not be given to infants under the age of twenty-four months.
- 19.1.4 A patient who receives general anaesthesia or procedural sedation should only leave the facility in the care of an adult.
- 19.1.5 Procedural sedation must be administered by or under the direct supervision of a member with appropriate training acceptable to the College to provide procedural sedation.
- 19.1.6 A patient who receives procedural sedation must be attended by a registered nurse or a member who is not assisting in the surgical

procedure and who is trained to monitor patients under procedural sedation.

19.1.7 All personnel who administer anaesthesia, major regional block or procedural sedation or who monitor the recovery of patients who receive anaesthesia, major regional block or procedural sedation must maintain a current certificate of proficiency in basic cardiopulmonary resuscitation.

19.1.8 There must be at least two personnel who are certified in basic cardiopulmonary resuscitation within the facility while patients are receiving care.

19.1.9 All equipment for the administration of anaesthetics must be readily available, clean and properly maintained.

19.2 A member must:

19.2.1 be in the room at all material times during the performance of a procedure in the facility.

19.2.2 ensure that following any procedure patients receive an adequate recovery period under supervision before leaving the facility.

19.2.3 be responsible for the post-operative care of the patient within the facility.

19.2.4 ensure qualified support staff are be on duty during and after a procedure in the facility.

19.2.5 maintain accurate information concerning the medical condition of patients in a clinical record which meets the expected standards of medical record-keeping, including documentation related to the informed consent of the patient for the procedure(s) performed in a facility.

19.2.6 perform procedures in a facility only if the facility has adequately equipped and maintained operating and post-operative rooms and all equipment is safe, well maintained and compliant with applicable federal, provincial, and municipal legislation.

19.3 A procedure within the cranium, the thorax, or the abdomen and major joint surgery may be performed, assisted or provided in a facility only where the committee has given its written authorization to the facility to perform the procedure, which authorization may include conditions or restrictions specified by the committee.

Article 20 - Facility Director

20.1 The facility shall appoint a facility director, who is a member acceptable to the committee, and who must:

20.1.1 be responsible for the administration of the facility;

20.1.2 enforce the standards of care in the facility, which include the safe and effective care of patients in the facility;

20.1.3 have access to all records and documents relating to the operation of the facility and the procedures performed therein;
20.1.4 develop appropriate and up-to-date policy and procedure manuals, including acceptable staff health policies;
20.1.5 ensure the duties and responsibilities of all personnel are written and understood;
20.1.6 ensure the requirements for granting privileges are met and the necessary approvals are obtained;
20.1.7 ensure sufficient numbers of appropriately trained personnel are present during procedures;
20.1.8 ensure procedures and equipment are appropriate and safe;
20.1.9 ensure agreements are in place for the emergency transfer and admission of patients as required herein;
20.1.10 ensure complete and accurate confidential patient records and documentation relating to the operation of the facility and procedures performed are kept;
20.1.11 ensure adequate quality assurance and improvement programs, including the monitoring of infection and medical complication rates, are in place;
20.1.12 ensure only those eligible procedures which are approved by the committee as set out in the certificate of accreditation are performed at the facility by members; and
20.1.13 ensure complete records are kept of all members who obtain privileges at the facility, including their applications and to make such records available to the committee or its designates on request.
20.1.14 ensure documentation, fees and a complete reporting of all required information to the College is submitted.
20.1.15 ensure that persons who provide services to the vacility have appropriate qualifications and maintain competence to perform the procedures for which the facility is accredited;
20.1.16 promptly notify the College of any change in ownership of the facility;
20.1.17 promptly notify the College if the facility is no longer providing patient services;
20.1.18 promptly notify the College if there is a major change in equipment or the accredited list of procedures.

Article 21 - Audit and Quality Control

21.1 All certificates of accreditation are subject to the following conditions:
21.1.1 All procedures and all clinical records must comply with the requirements of standards of care set by the College.
21.1.2 Quality assurance and improvement programs are in place sufficient to demonstrate that standards of patient care set by the College are met in the facility.
21.1.3 At least annually the director must review the facility's quality assurance and improvement programs.
21.1.4 Within 30 days of each calendar year end, the facility must forward an annual report to the College outlining:
21.1.4.a the number and types of procedures performed in the facility;

21.1.4.b the number and type of adverse outcomes, including infections and complications, arising from procedures done in the facility;
21.1.4.c quality improvement program initiatives in the facility; and
21.1.4.d the number of transfers to hospital from the facility.

Article 22 - Infection Control

22.1 A facility must:
22.1.1 use sterilization techniques,
22.1.2 store medical and dental supplies, and
22.1.3 use waste handling and disposal procedures
consistent with the standards applicable to infection control and waste handling and disposal in a hospital.

22.2 A facility must comply with all guidelines the College may require the facility to comply with to meet best practices on the subject of infection control practices in a facility setting.

Article 23 - Appeal

23.1 The facility or a member may appeal any decision of the committee to the Executive Committee pursuant to sections 183 and 38 of the RHPA by filing a Notice of Appeal with the Registrar within thirty days of being informed of the decision.

Article 24 - Inspections and Audits

24.1 At any time and at the cost of the facility, a facility is subject to on-site inspection by members designated by the committee to conduct inspections.

24.2 If access to the facility for any inspection is refused, the committee may take such action it deems necessary including, suspending, revoking or amending the facility's certificate of accreditation.

24.3 The Committee may appoint an investigator with powers under s. 183(6) of the RHPA.

Article 25 - Administration Fees for Facilities

25.1 The facility shall pay all expenses, charges and fees including any licence fees imposed by the committee, in respect of the administration of Part B of this Bylaw.

Article 26 – Transition

26.1 All accreditations and approvals of facilities, procedures, facility directors, conditions granted at the time this Bylaw comes into force continues to be valid.